

area, an amount equal to the weighted average of annual capitation rates for each local area (county) in the plan's service area, using as weights the projected number of enrollees in each MA local area that the plan used to calculate the bid amount, and adjusted as appropriate for the purpose of risk adjustment.

(b) For MA regional plans, the term "MA region-specific non-drug monthly benchmark amount" is:

(1) The sum of two components: the statutory component (based on a weighted average of local benchmarks in the region, as described in paragraph (c)(3) of this section; and the plan bid component (based on a weighted average of regional plan bids in the region as described in paragraph (c)(4) of this section).

(2) Announced before November 15 of each year, but after CMS has received the plan bids.

(c) *Calculation of MA regional non-drug benchmark amount.* CMS calculates the monthly regional non-drug benchmark amount for each MA region as follows:

(1) *Reference month.* For all calculations that follow, CMS will determine the number of MA eligible individuals in each local area, in each region, and nationally as of the reference month, which is a month in the previous calendar year CMS identifies.

(2) *Statutory market share.* CMS will determine the statutory national market share percentage as the proportion of the MA eligible individuals nationally who were not enrolled in an MA plan.

(3) *Statutory component of the region-specific benchmark.* (i) CMS calculates the unadjusted region-specific non-drug amount by multiplying the county capitation rate by the county's share of the MA eligible individuals residing in the region (the number of MA eligible individuals in the county divided by the number of MA eligible individuals in the region), and then adding all the enrollment-weighted county rates to a sum for the region.

(ii) CMS then multiplies the unadjusted region-specific non-drug amount from paragraph (c)(3)(i) of this section by the statutory market share

to determine the statutory component of the regional benchmark.

(4) *Plan-bid component of the region-specific benchmark.* For each regional plan offered in a region, CMS will multiply the plan's unadjusted region-specific non-drug bid amount by the plan's share of enrollment (as determined under paragraph (c)(5) of this section) and then sum these products across all plans offered in the region. CMS then multiplies this by 1 minus the statutory market share to determine the plan-bid component of the regional benchmark.

(5) *Plan's share of enrollment.* CMS will calculate the plan's share of MA enrollment in the region as follows:

(i) In the first year that any MA regional plan is being offered in an MA region, and more than one MA regional plan is being offered, CMS will determine each regional plan's share of enrollment based on one of two possible approaches. CMS may base this factor on equal division among plans, so that each plan's share will be 1 divided by the number of plans offered. Alternatively, CMS may base this factor on each regional plan's estimate of projected enrollment. Plan enrollment projections are subject to review and adjustment by CMS to assure reasonableness.

(ii) If two or more regional plans are offered in a region and were offered in the reference month: The plan's share of enrollment will be the number of MA eligible individuals enrolled in the plan divided by the number of MA eligible individuals enrolled in all of the plans in the region, as of the reference month.

(iii) If a single regional plan is being offered in the region: The plan's share of enrollment is equal to 1.

§ 422.262 Beneficiary premiums.

(a) Determination of MA monthly basic beneficiary premium. (1) For an MA plan with an unadjusted statutory non-drug bid amount that is less than the relevant unadjusted non-drug benchmark amount, the basic beneficiary premium is zero.

(2) For an MA plan with an unadjusted statutory non-drug bid amount that is equal to or greater than the relevant unadjusted non-drug

benchmark amount, the basic beneficiary premium is the amount by which (if any) the bid amount exceeds the benchmark amount. All approved basic premiums must be charged; they cannot be waived.

(b) *Consolidated monthly premiums.* Except as specified in paragraph (b)(2) of this section, MA organizations must charge enrollees a consolidated monthly MA premium.

(1) The consolidated monthly premium for an MA plan (other than a MSA plan) is the sum of the MA monthly basic beneficiary premium (if any), the MA monthly supplementary beneficiary premium (if any), and the MA monthly prescription drug beneficiary premium (if any).

(2) *Special rule for MSA plans.* For an individual enrolled in an MSA plan offered by an MA organization, the monthly beneficiary premium is the supplemental premium (if any).

(c) *Uniformity of premiums—(1) General rule.* Except as permitted for supplemental premiums pursuant to § 422.106(d), for MA contracts with employers and labor organizations, the MA monthly bid amount submitted under § 422.254, the MA monthly basic beneficiary premium, the MA monthly supplemental beneficiary premium, the MA monthly prescription drug premium, and the monthly MSA premium of an MA organization may not vary among individuals enrolled in an MA plan (or segment of the plan as provided for local MA plans under paragraph (c)(2) of this section). In addition, the MA organization cannot vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any) among individuals enrolled in an MA plan (or segment of the plan).

(2) *Segmented service area option.* An MA organization may apply the uniformity requirements in paragraph (c)(1) of this section to segments of an MA local plan service area (rather than to the entire service area) as long as such a segment is composed of one or more MA payment areas. The information specified under § 422.254 is submitted separately for each segment. This provision does not apply to MA regional plans.

(d) *Monetary inducement prohibited.* An MA organization may not provide

for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose.

(e) *Timing of payments.* The MA organization must permit payments of MA monthly basic and supplemental beneficiary premiums and monthly prescription drug beneficiary premiums on a monthly basis and may not terminate coverage for failure to make timely payments except as provided in § 422.74(b).

(f) *Beneficiary payment options.* An MA organization must permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(1) Withholding from the enrollee's Social Security benefit payments, or benefit payments by the Railroad Retirement Board or the Office of Personnel Management, in the manner that the Part B premium is withheld;

(2) An electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account);

(3) According to other means that CMS may specify, including payment by an employer or under employment-based retiree health coverage on behalf of an employee, former employee (or dependent), or by other third parties such as a State.

(i) Regarding the option in paragraph (f)(1) of this section, MA organizations may not impose a charge on beneficiaries for the election of this option.

(ii) An enrollee may opt to make a direct payment of premium to the plan.

§ 422.264 Calculation of savings.

(a) *Computation of risk adjusted bids and benchmarks.* (1) *The risk adjusted MA statutory non-drug monthly bid amount* is the unadjusted plan bid amount for coverage of original Medicare benefits (defined at § 422.254), adjusted using the factors described in paragraph (c) of this section for local plans and paragraph (e) of this section for regional plans.

(2) *The risk adjusted MA area-specific non-drug monthly benchmark amount* is the unadjusted benchmark amount for coverage of original Medicare benefits by a local MA plan (defined at § 422.258),